STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155724	A. BUILDING 00 B. WING	08/29/2011

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WOODBRIDGE HEALTH CAMPUS	602 WOODBRIDGE AVE LOGANSPORT, IN46947

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F0000	This visit was for the Investigation of Complaint IN00095588. Complaint IN00095588 - Substantiated. Federal/State deficiencies related to the allegation are cited at F-309. Survey dates: August 26 and 29, 2011 Facility number: 003691 Provider number: 155724 AIM number: 200456230 Survey team: DeAnn Mankell, RN Census bed type: SNF: 43 SNF/NF: 20 Residential: 18 Total: 81 Census payor type: Medicare: 21 Medicaid: 19 Other: 41 Total: 81 Sample: 3 These deficiencies also reflect state findings cited in accordance with 410 IAC	F0000	Submission of this plan of correction does not constitue an admission by WoodBridge Health Campus of any wrong-doing or failure to comply with the Federal or State Regulations.WoodBridge Health Campus submits this plan of correction as its letter of credible allegation.Corrective Actions accomplihsed for those residents found to have been affected by the alleged deficient practice: Resident #A expired. No other residents were identified as being affected by this alleged deficient practice.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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F0309 SS=G	16.2. Quality review 9/02/11 by Suzanne Williams, RN Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to provide CPR (cardio-pulmonary resuscitation) to 1 of 2 residents, with signed advance directives directing the facility to provide CPR, thus resulting in the death of the resident, in a sample of 3 (Resident A). Findings include: 1. Resident A's clinical record was reviewed on 8/26/2011 at 2:05 P.M. Resident A's diagnoses included, but were not limited to, hypertension, pulmonary fibrosis, diabetes mellitus, allergic rhinitis, anorexia, muscle weakness, coronary artery disease, congestive heart failure, and complete heart block with a pacemaker. Resident A's CPR Consent form indicated the section for "It is my desire that I be given:" the box next to CPR had an "x" in it. This form was signed by the resident's daughter on 2/23/2011.	F0309	Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:All residents have the potential to be affected by this alleged deficent practice; Therefore, an immediate nursing inservice was conducted by the ADHS on "Cardiopulmonary Resuscitation policy" and the protocols on how to identify this information.An audit was completed by the Social Services Director on all present residents in the building. Every resident's chart was checked to assure the advance directives, physician's orders, care plan, face sheets and twenty four hour report sheets all agreed.The DHS reviewed the clinical records of all residents who died in the building over the past 6 months to ensure the residents advance directives had been followed. No other residents were identified.Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:Nursingstaff have been inserviced on the	09/28/2011

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	Resident A's nurse's notes for 8/23/2011 indicated: 1520 (3:30 P.M.) "Aid needed (name of CNA #1) help pulling res (resident) up in bed (sic) went (sic) into room. Res. was lying on side et was pale, spoke with Res he said he was not feeling well, I immediately check Res. blood sugar it was 146 check his O2 (oxygen) machine was set on 5L et was feed (sic) oxygen SAT 98%. Res smelled of urine (changed indicated by a triangle) Res brief. Went to get replacement sheets et then sat Res. up to move out of bed since Res couldn't help c (with) changing bed. When we had the Res standing his legs buckled. We then set him on the floor et went to get some help. (LPN #1) et (CNA #2) both came in the room. O2 SAT was still at 97% et held. Res was still responsive. Respriations (sic) 26, Pulse 95 et was unable to get B/P. While trying to get a B/P the O2 monitor started dropping steadly (sic). Then Res was quickly moved back into bed assist x 4. Res was unresponsive thoratic (sic) chest rubs were done by self et (LPN #1) then I went et called 911. When I returned (LPN #1) et (RN #1) were trying to arouse Res. (RN #1) called his death at 1540 (3:40 P.M.). Late note before going to call 911 we did try getting a pulse could not feel one. (LPN #1) was getting a weak apical		"cardiopulmonary resuscitation poliy" and the protocols on how to identify this information.This Inservice information is incorporated into the orientation for all nursing staff. This will be an ongoing practice.The Social Services Director or designee will review and audit charts on all new admissions to ensure advance directives, orders, 24 hour report sheets, care plans and face sheets all agree. This will also be an ongoing practice for this facility.How the corrective measures will be monitored to ensure the alleged deficient practice does not recur.The social services director will audit all new admission charts to assure all information matches as stated above. This will be completed on the first business day following admission. This will be an ongoing practice.The DHS or Designee will ask three random nursing staff each week on the policy of"cardiopulmonary resuscitatioin" and their response to such an event. Anyone identified as not understanding will be re-inserviced at the time they are identified. The DHS or Designee will ask three nursing staff weekly times 4 weeks, then monthly times 5 months. The results will be presented to Qyality Assurance montly for review and additional recommendations if indicated.Addendum; F309: What is the facility system to ensure	

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	pulse...." signed by LPN #2 1540 (3:40 P.M.) (Name of RN #1) heard nurse say that (Resident A) was unresponsive arrived in (Room #). Saw pts. feet were cyanotic bilaterally. I approached resident and no signs of life were present. Auscultated (sic) Carotid pulse nothing (indicated by a circle with a line through it). Auscultated apical pulse nothing (indicated by a circle with a line through it). No B/P. No SaO2 sat level noted on oximety (sic). Gave 3 sternal rubs c (with) no response. Resident time of death 1540 (3:40 P.M.) signed by RN #1 1610 (4:10 P.M.) "@ 1525 (3:25 P.M.) writer heard Maple Wood nurse state 'I need help picking (Resident A) up (indicated by an arrow pointing up).' Writer went in to room resident unresponsive, went for V/S equipment while doing this told Med Rec. (Medical Records). RN (RN #1) resident was unresponsive gathered equipment went into room. O2 97%, P 95, R 26, V/S held for 3 minutes then rapidly declined to O. Never able to attain B/P. 911 called." signed by LPN #1. The "Cardiopulmonary Resuscitation Circumstance, Assessment and Intervention" form was provided by the		that any advance directive changes for a resident,not just for the new admission,will be coordinated in all records?The social Service Director or designee will be discussing the change regarding the advance directive with the family/resident or representative. With the change noted, the social Services Director will be reponsible to assure the clinical record is accurate to reflect the change. The Social Service Director will also be responsible to change all the residents records to reflect the change. The Social Services Director will add the resident to the audit log and check all reas for accuracy. This will be an ongoing system change for our facility.	

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	Administrator on 8/26/2011 at 3:30 P.M. This form indicated on 8/23/2011 Resident A was assessed by RN #1, LPN #1, and LPN #2. RN #1 and LPN #1 had identified the resident's condition. His skin was pale, pulse was 95, he had a pacemaker, no blood pressure, respirations were 24-26 and shallow with an O2 Saturation of 97%. The "resident went unresponsive during the assessment." The "Res. was a full code & CPR Not initiated." The comments were "Res. had been a full code & nurses did not initiate CPR. Senior nurse RN stated time of death 1540 (3:40 P.M.)." The "24 hour nursing report" form with the date of 08/23/2011 was reviewed. Resident A's instruction were reviewed. He was listed as a "full code." There was a notation of "Res. passed away 1540 (3:40 P.M.)" The Administrator provided the facility's investigation regarding Resident A's lack of CPR on 8/26/2011 at 3:30 P.M. LPN #2's statement obtained on 8/23/11 at 1700 (5:00 P.M.) indicated she was "Notified by (CNA #1) that (Resident A) was on the floor. Asked (LPN #1) for assistance due to (Resident A) on floor took vitals equipment & went to room. (CNA #2, CNA #1, LPN #1) and I were assessing & O2 sats OK but having			

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	trouble getting B/P. He was talking but hard to understand. Returned him to bed & O2 sats started dropping. Asked Code status & no one knew. Left to go check. Returned & told Code status then tried to call 911 from room did not work so went to station & called. Came back to room. (LPN #1 and RN #1) there (sic) and said at least 2 X's he is a full code are we going to do CPR. (RN #1) said no he is already gone & I already called it. Instinct said to do CPR but did not since they said no they were seasoned nurses. (LPN #1) had said at some time he had blood in his mouth." The facility attempted to get a statement from LPN #1; on 8/23/2011 at 1705 (5:05 P.M.) she told the DON, "'Why would we do CPR, he had a pace maker & you are not going to save him.' Stated again he was a full code & I needed her statement as to what she saw. 'Why would I rewrite what is in NN (nurses' notes)'.... Did not get any written statement from (LPN #1)." RN #1 and LPN #1 were suspended on 8/24/2011. The record from EMS was obtained on 8/29/2011 at 12:50 P.M. The EMS record indicated on 8/23/2011 at 15:42 (3:42 P.M.) a call was received from (address of facility) for a "full code." EMS			

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	responded, but found "no patient." The notes indicated "On arrival at extended care facility found ECF (extended care facility) staff at nurse (sic) station. When asked by EMS where patient located? (RN #1) in charge stated 'Pt. already gone." Asked by EMS 'gone where'? and if there was a 'code' (cardiac arrest) in progress. Same nurse stated, 'Pt in room but had already passed.' EMS crew dismissed at that time, no patient information was obtained at that time or contact made with patient." There was a time line on the form "Call received 1542 (3:42 P.M.) Crew Enroute 1542 (3:42 P.M.) Arrive at scene 1543 (3:43 P.M.) Cleared scene 1546 (3:46 P.M.) Back at hospital 1550 (3:50 P.M.)" CNA #1 was interviewed on 8/26/2011 at 4:45 P.M., she indicated on 8/23/2011 she had answered Resident A's call light. She had gotten LPN #2 because the resident had said he didn't feel well and LPN #2 had come into the room to assess him, but they had smelled urine, so they changed him, but needed to change the bed as it was urine soaked. They got him out of bed, but when he was standing up, his knees buckled. They sat him on the floor and LPN #1 came into the room and helped to place him back into the bed. As he was on the floor, he went			

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	unresponsive. When he was back in the bed, RN #1 came into the room, rubbed his chest and called his time of death. She indicated LPN #2 told them 2 times that Resident A was a full code. She indicated EMS came to the facility, but never made it to the room. CNA #2 was interviewed on 8/26/2011 at 4:56 P.M. He indicated he only came into the room to help get the resident off the floor and back into bed. He indicated the resident had no signs of response, but he left the room as soon as the resident was back in bed. RN #1 was interviewed on 8/26/2011 at 4:50 P.M. She indicated she was working in the Medical Record room. She indicated she looked out her door and saw a CNA running and CNA #1 coming back down the hall. She said the CNA was tearful and said Resident A had passed. She went to Resident A's door and his feet were cyanotic. She said LPN #1 and LPN #2 were in the room. She said they told her Resident A had passed. She took the stethoscope, listened, and heard no pulse or breathing and he was cold to touch. She said his pacemaker had stopped. She called the time of death at 3:40 P.M. LPN #2 then asked "What do we do now?" She indicated she told her to call the family and the mortuary. She said she			

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	asked if he was a code or no code. She indicated she froze when she heard he was a code and her mind went blank. She said she had been in the room for 5-6 minutes. She said when EMS arrived she had told them "He's gone" and EMS never went to the resident's room. LPN #1 was interviewed on 8/29/2011 at 1:15 P.M. She indicated on 8/23/2011 at 15:25 (3:25 P.M.) the CNA and LPN #2 asked for help. She got CNA # 2 and the Hoyer lift. She said CNA #1 was holding Resident A up and holding his head up. He had no B/P, but his pulse oximetry was 92% with a pulse of 95. He had shallow respirations for 3 minutes and then none. She hollered for RN #1. She told LPN #3 and the DON as she got the items she needed to take his vital signs and then went back into the room. They got Resident A into bed by physically lifting him. He had no blood pressure. A sternal rub was attempted. RN #1 came into the room. LPN #2 had attempted to call 911 in the room, but she couldn't get the phone to work. She left the room and called 911 from the nurses' desk. RN #1 had come into the room and said Resident A's feet were blue. She said LPN #2 had returned to the room, but she had her back to her and didn't hear what she said. RN #1 said "No, I'm calling time of death 1540 (3:40 P.M.)." She indicated they left			

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	the room and went to the nurses' desk where she helped LPN #2 with the paperwork. EMS arrived and RN #1 told them he was gone. She indicated she never asked what Resident A's code status was. She indicated she had never heard if he was a code. She indicated she did not know who had called 911. LPN #2 was interviewed on 8/29/2011 at 2:00 P.M. She indicated on 8/23/2011 CNA #1 had came out of Resident A's room and had stopped her and pulled her into Resident A's room. Resident A said he didn't feel good. She had assessed him and checked his blood sugar which was 146 and his oxygen was on with a saturation of 98%. He was wet and had diarrhea. They changed him, but his entire bed was wet, so they assisted him out of bed to change the bed and to try to dry the bed out as he was on an air flow mattress. She indicated her plan was to leave him up for a while for the bed to dry out. When he stood up his knees buckled so he was lowered to the floor. She left CNA #1 with him to get help. She got LPN #1 who came first and then CNA #2 came into the room. By this time his head was hanging. LPN #1 went out of the room for a BP cuff and she went out of the room for clean linens. His pulse was 95, but his B/P was unable to be heard. His pulse oximeter was 92% and then			

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	slowly dropped. They had 4 people who lifted him into bed. He was no longer responsive before they got him back in bed. He had been talking when he was sitting on the floor. LPN #2 said she gave him some chest rubs and he had no radial pulse. She asked if anyone knew if he was a code. She left and pulled his chart which indicated he was a full code. She returned to the room and told CNA #1 and LPN #1 that he was a code and attempted to call 911 from the room, but was unable to get a line. She returned to the nurses' desk and called 911 about 3:30 P.M. or 3:35 P.M., she was unsure of the time. She then returned to his room and told them she had called 911 and they were on their way and shouldn't we start CPR. RN #1 said "he's gone" and "No." She indicated this was the first she had noticed RN #1 was in the room. She indicated she had left the room, but stopped outside the door, and comforted CNA #1 who was crying. She then walked to the nurses' desk and EMS had arrived. She indicated RN #1 had called his death at 15:40 (3:40 P.M.). She could not remember if RN #1 was in the room when she had called 911. She said she didn't know why she didn't do CPR, but she was a new nurse and still had questions and RN #1 had been her supervisor and she had not done CPR. The personnel files of LPN #1, LPN #2,			

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	and RN #1 were reviewed on 8/26/2011 at 4:00 P.M. All of 3 had been CPR certified and had gone over CPR during their orientation. Review of the CPR certification listing maintained by the facility indicated 42 of 66 nursing staff members were CPR certified. RN #1 and LPN #1 were terminated on 8/29/2011. On 8/26/2011 at 3:30 P.M., the Administrator provided a packet of information which included the facility's investigation of the CPR not being administered to Resident A. In this packet were inservices on the "Cardiopulmonary Resuscitation Policy." All employees in the building were given this inservice and had signed they were in the inservice. This packet of information included a form with all residents in the building listed. The facility had used this to check every chart in the building in ensure the advanced directives, physician's orders, care plans, face sheet, and 24 hour sheet all agreed. The facility had reviewed all deaths in the building occurring in the past 6 months to ensure the resident's advanced directives had been followed and found all who had died were no codes, and the advanced directives were			

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	honored. On 8/26/2011 between 4:40 P.M. and 4:45 P.M., seven resident clinical records were reviewed, with all seven having agreement of the advanced directives, physician's orders, face sheet, and 24 hour sheet. Review of the undated policy for Cardiopulmonary Resuscitation (CPR) was provided by the DON on 8/26/2011 at 3:30 P.M. The policy indicated "....5. If the resident is a 'Full Code" and is found to be in cardiopulmonary arrest campus staff will: a. Assess for viable signs of life, measurable blood pressure, skin temperature, skin color/cyanosis, pulse (absence, rhythm, quality), respirations (absence, rhythm, quality, level of consciousness). b. Initiate CPR. c. Call 911 to have the emergency medics transport the resident to the nearest hospital. d. Notify the attending physician or medical director for instructions...." This federal tag relates to complaint IN00095588. 3.1-37(a)			